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Florida v. HHS - Amicus Brief of American Nurses Association et al.

American Nurses Association

Nos. 11-11021 & 11-11067

IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

STATE OF FLORIDA, by and through Attorney General Pam Bondi, et al.,

Plaintiff-Appellees/Cross-Appellants,
v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,

Defendant-Appellants/Cross-Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF FLORIDA

BRIEF OF AMICI CURIAE AMERICAN NURSES ASSOCIATION; AMERICAN ACADEMY OF PEDIATRICS; AMERICAN MEDICAL STUDENT ASSOCIATION; CENTER FOR AMERICAN PROGRESS D/B/A DOCTORS FOR AMERICA; NATIONAL HISPANIC MEDICAL ASSOCIATION; AND NATIONAL PHYSICIANS ALLIANCE IN SUPPORT OF APPELLANTS AND REVERSAL

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Corporate Disclosure Statement and Certificate of Interested Persons

Pursuant to Federal Rule of Appellate Procedure 26.1, counsel certifies that no signatory to this brief has a parent corporation and that no publicly held corporation owns 10 percent or more of its stock.

Pursuant to 11th Cir. R. 26.1-1, counsel certifies that, to the best of his knowledge, the persons, firms, and associations listed in appellants Amended Certificate of Interested Persons represents a complete list of all persons and organizations that may have an interest in the outcome of this case, with the addition of three signatories to this amicus brief who did not participate in this case at the district court level:

American Medical Student Association

National Hispanic Medical Association

National Physicians Alliance

/s/Ian Millhiser
Counsel for *Amici Curiae*

APRIL 7, 2011

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STATEMENT OF ISSUES

Whether Congress' power "to make all laws which shall be necessary and proper for carrying into execution" a regulation of interstate commerce permits it to choose the means by which it regulates the buying and selling of health care.

Interests of the *Amici Curiae*[1]

Amici are diverse health care provider organizations representing millions of doctors, nurses and other health care professionals throughout the country. *Amici* believe that the Affordable Care Act is a significant achievement for the patients that their members serve because it ensures greater protection against losing or being denied health insurance coverage and it promotes better access to primary care and to wellness and prevention programs. The Act's goal of optimizing health insurance coverage for the greatest number of people permits healthcare professionals to place their attention on the most important thing—the patient's well-being and healing—rather than on economic considerations.

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[1] This brief is filed with the consent of the parties pursuant to Federal Rule of Appellate Procedure 29(a). Pursuant to Federal Rule of Appellate Procedure 29(c)(5), counsel for *amici* represent that no counsel for a party authored this brief in whole or in part and that none of the parties or their counsel, nor any other person or entity other than *amici*, its members or its counsel made a monetary contribution intended to fund the preparation or submission of this brief.

Amici have a significant interest in assisting the Court in understanding that the minimum coverage provision challenged by plaintiffs is essential to the Affordable Care Act's provisions ensuring that health insurance is both universally available and affordable. Because *amici*'s members work on the front lines of the health care system, they know from experience that patients who put off needed care due to lack of insurance often end up sicker and require much costlier emergency room care. Moreover, *amici*'s members work throughout the continuum of care and in all settings within the health care industry—from direct care to hospital administration. As a result, *amici* have a uniquely broad perspective on the impact of the Affordable Care Act and the capacity to offer information that can guide the court's understanding of the consequences of removing the minimum coverage provision to the health provider, patients, and insurance markets as a whole.

SUMMARY OF ARGUMENT

Congress enacted the Patient Protection and Affordable Care Act, Pub L. No. 111-148, 124 Stat. 119 (2010) ("ACA") to achieve near-universal health insurance coverage, significantly reduce the economic costs of poor outcomes among presently uninsured Americans, prevent cost shifting from uninsured Americans receiving uncompensated care to Americans with

insurance, and improve the financial security of all families against medical costs. § 10106(a). Yet, as Congress determined in enacting the ACA, the reforms enacted to achieve these goals cannot function effectively without a provision requiring all Americans who can afford insurance to either obtain it or pay an additional portion of their income with their annual tax return.[2] § 1501(a)(2)(G). Although Defendant correctly argues that the minimum coverage provision is a valid exercise of Congress' Commerce and Taxing powers, these arguments are ultimately unnecessary to uphold the ACA. The minimum coverage provision is essential to ensuring that the ACA's insurance regulations function effectively—and this fact alone compels this Court to uphold the Act under the Necessary and Proper Clause. *See Gonzales v. Raich*, 545 U.S. 1, 22 (2005) (holding that courts should "refuse to excise individual components" of a larger regulatory scheme even when those components could not be enacted on their own under the Commerce Clause); *id.*at 36 (Scalia, J., concurring in the judgment) ("where Congress has the authority to enact a regulation of interstate commerce, 'it possesses *every power* needed to make that regulation effective.'" (quoting *United*

[2] The ACA labels this provision the "Requirement to Maintain Minimum Essential Coverage." § 1501. The provision is referred to as the "minimum coverage provision" throughout this brief.

States v. Wrightwood Dairy Co., 315 U.S. 110, 118 (1942)) (emphasis added)).

The necessary link between the ACA's minimum coverage provision and its insurance regulations is proven by the experience of every single state to require insurers to cover persons with preexisting conditions without also enacting a minimum coverage provision. *See* Brief of *Amici Curiae* American Association of People with Disabilities, *et al*, at 5–11. Seven states enacted preexisting conditions laws without also enacting a minimum coverage provision, and all seven stakes experienced sharp spikes in insurance premiums—or worse. *Id.* Kentucky, Maine, New Hampshire and Washington each lost most or all of their individual market insurers after those states enacted a preexisting conditions provision without enacting a minimum coverage provision, and the cost of some New Jersey health plans more than tripled after that state enacted a similar law. *See infra* at 21.

This necessary link between the ACA's insurance regulations and the minimum coverage provision also distinguishes this provision from hypothetical laws compelling the purchase of consumer goods or other items. There is no federal law which depends upon mandatory car ownership or mandatory vegetable purchases, for example, in order to function properly in the same way that the ACA's preexisting conditions provision can only

function properly in the presence of a minimum coverage provision. Accordingly, the Necessary and Proper Clause does not provide a constitutional basis for such hypothetical laws in the same way that it supports the minimum coverage provision. *See Raich*, 545 U.S. at 38 (Scalia, J., concurring in the judgment) ("[T]he power to enact laws enabling effective regulation of interstate commerce can only be exercised in conjunction with congressional regulation of an interstate market, and *it extends only to those measures necessary to make the interstate regulation effective*." (emphasis added)).

The Necessary and Proper Clause also empowers Congress to ensure that federal monies are not spent wastefully. *See Sabri v. United States*, 541 U.S. 600, 605 (2004). Many health conditions and illnesses, if caught early and treated with appropriate follow-up care, can be relatively inexpensive to resolve. Many conditions can be avoided altogether through preventive care. Yet if these conditions or illnesses do not receive prompt and appropriate treatment, they can often require hospitalization or otherwise deteriorate into a serious condition requiring expensive care. *See* Institute of Medicine, Health Insurance is a Family Matter 106 (2002). Because federal law requires virtually all emergency rooms to stabilize patients regardless of their ability to pay, *see* Emergency Medical Treatment and Labor Act, 42

U.S.C. § 1395dd., the cost of this expensive care winds up being transferred to patients with insurance or to government programs such as Medicare or Medicaid.

Uninsured patients who are near the retirement age are also likely to be less healthy than their insured counterparts when they enter the Medicare program. As a result, previously uninsured Medicare beneficiaries with common conditions such as diabetes or heart disease "reported 13 percent more doctor visits, 20 percent more hospitalizations, and 51 percent more total medical expenditures" than similarly situated patients who were insured prior to qualifying for Medicare. J. Michael McWilliams, *Health Consequences of Uninsurance Among Adults in the United States: Recent Evidence and Implications*, 87 Milbank Q. 443, 468 (2009) ("Uninsurance Among Adults")

By encouraging nearly all Americans to join insurance pools, the minimum coverage provision empowers patients to seek treatment before their conditions become prohibitively expensive to treat and it prevents the costs of their treatment from being transferred to taxpayer-funded programs. This provides a second reason why the Court should uphold the minimum coverage provision. *See Sabri*, 541 U.S. at 605.

ARGUMENT

A. The Necessary and Proper Clause Empowers Congress to Enact Provisions That Are Reasonably Adapted To Making A Broader Regulatory Scheme Effective

1. The Necessary and Proper Power is Broad

"[T]he Necessary and Proper Clause makes clear that the Constitution's grants of specific federal legislative authority are accompanied by broad power to enact laws that are 'convenient, or useful' or 'conducive'" to an enumerated power's "beneficial exercise." *United States v. Comstock*, 130 S. Ct. 1949, 1956 (2010) (quoting *McCulloch v. Maryland*, 17 U.S. (4 Wheat.) 316, 413, 418 (1819)). Moreover, "Chief Justice Marshall emphasized that the word 'necessary' does not mean 'absolutely necessary.'" *Id.* Rather, "[I]n determining whether the Necessary and Proper Clause grants Congress the legislative authority to enact a particular federal statute, [courts] look to see whether the statute constitutes a means that is *rationally related* to the implementation of a constitutionally enumerated power." *United States v. Belfast*, 611 F.3d 783, 805 (11th Cir. 2010) ((quoting *Comstock*, 130 S.Ct. at 1956) (emphasis in original)).

The Affordable Care Act does not "regulate inactivity," as the district court suggests. *Florida v. Department of Health and Human Services.*, No.

3:10-cv-91, 2011 U.S. Dist. LEXIS 8822, at *78 (N.D. Fl. Jan. 31, 2001). The ACA regulates the buying and selling of health care. Both the Supreme Court's earliest cases and its most recent Necessary and Proper case establish that Congress has plenary authority to select the means by which it regulates commercial markets. *See Comstock*, 130 S.Ct. at 1956 ("[I]n determining whether the Necessary and Proper Clause grants Congress the legislative authority to enact a particular federal statute, we look to see whether the statute constitutes a means that is rationally related to the implementation of a constitutionally enumerated power."); *McCulloch*, 17 U.S. (4 Wheat.) at 421 ("Let the end be legitimate, let it be within the scope of the constitution, and all means which are appropriate, which are plainly adapted to that end, which are not prohibited, but consist with the letter and spirit of the constitution, are constitutional."); *see also Gibbons v. Ogden*, 22 U.S. (9 Wheat.) 1, 196–97 (1824) (holding that Congress' enumerated powers "may be exercised to [their] utmost extent, and acknowledge[] no limitations, other than are prescribed in the constitution" and that Congress' power is "plenary" with respect to interstate commerce).

Rather than follow nearly 200 years of settled precedent, the district court imposed a novel, extra-constitutional limit on Congressional power—holding that Congress may not require a temporarily inactive health care

consumer to take a particular action. Yet even if it were true that individuals subject to the minimum coverage provision are not active participants in the health care market, *see generally* Brief of *Amici Curiae* Economic Scholars, the district court's activity/inactivity distinction finds no support in precedent. *See Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 297 (1990) (Scalia, J., concurring) (describing a legal distinction between laws regulating action and those regulating inaction as "specious"). As Justice Scalia explains, "where Congress has the authority to enact a regulation of interstate commerce, 'it possesses *every power* needed to make that regulation effective.'" *Raich*, 545 U.S. at 36 (Scalia, J., concurring in the judgment) (quoting *Wrightwood Dairy Co.*, 315 U.S. at 118) (emphasis added); *see also Comstock*, 130 S.Ct at 1968 (Kennedy, J., concurring in the judgment) (explaining that Congress may exercise its necessary and proper power to ensure that another provision of law does "not put in motion a particular force . . . that endangers others").

Amici acknowledge that, while Congress' Necessary and Proper power is very broad, it is not without limits. When invoked as part of a comprehensive economic regulatory scheme, the Necessary and Proper power "can only be exercised in conjunction with congressional regulation of an interstate market, and it extends only to those measures necessary to

make interstate regulation effective." *Id.* at 38 (Scalia, J, concurring in the judgment). These conditions are met in this case, as the minimum coverage provision is necessary to make the related insurance reforms effective. When Congress enacts a unique regulatory scheme or regulates a unique market under its Commerce Power, the very uniqueness of such a law may bring new regulatory tools within the Necessary and Proper Clause's umbrella.

The Necessary and Proper Clause also empowers Congress to ensure that federal monies are not spent wastefully. In *Sabri v. United States*, 541 U.S. 600 (2004), the Supreme Court upheld a wide-reaching statute criminalizing bribery of any state official whose agency or government receives federal funds, even though the statute swept broadly to include officials who have no contact with the federal funds. As the Court explained, "Congress has authority under the Spending Clause to appropriate federal monies to promote the general welfare, and it has corresponding authority under the Necessary and Proper Clause to see to it that taxpayer dollars" are not "frittered away" by bribery-motivated projects that are not cost-effective. *Id.* at 605 (citations omitted).

2. The Necessary and Proper Power is Neither Coextensive with the Commerce Power Nor Bound Entirely By *Gonzales v. Raich*

The district court suggests that the Necessary and Proper Power is merely coextensive with Congress' Commerce Power, *See Florida*, U.S. Dist. LEXIS 8822, at *107 (holding that the Necessary and Proper Clause "is not an independent source of federal power"), or, alternatively, that *Gonzales v. Raich* sets the outer limit of Congress' power to enact laws necessary and proper to carry its Commerce Power into effect. *See id.* at *28 n. 7.[3] This suggestion cannot be squared with the Supreme Court's holding in *United States v. Comstock*.

Comstock involved three federal inmates convicted of unlawful possession of child pornography. 130 S.Ct. at 1955. After the inmates had completed their sentences, the government sought to prolong their detention under a federal law authorizing civil commitment of "sexually dangerous" federal inmates. *Id.* The *Comstock* plaintiffs convinced the Fourth Circuit that—even though the statute criminalizing possession of child pornography is a valid exercise of the Commerce Power, *United States v. Malloy*, 568

[3] Of course, it is ultimately irrelevant whether the Necessary and Proper power extends beyond the confines of *Raich*, because the Affordable Care Act is constitutional under the rule applied in *Raich* and similar cases. *See Mead v. Holder*, No. 10-950 at 41–44 (D.D.C. Feb. 22, 2001) (memorandum opinion granting motion to dismiss).

F.3d 166, 180 (4th Cir. 2009)—the statute allowing them to be detained beyond their original sentence did not fall within Congress' Commerce Power or its power under the Necessary and Proper Clause. *United States v. Comstock*, 551 F.3d 274, 284–85 (4th Cir. 2009) *rev'd* 130 S.Ct. at 1949.

In reversing, the Supreme Court did not contest the Fourth Circuit's conclusion that the civil commitment statute exceeds Congress' power under the *Lopez*/*Morrison*/*Raich* line of cases—nor could the justices reasonably have done so. The Fourth Circuit persuasively argued that *Raich* does not itself allow the civil commitment law in *Comstock* to stand. *See id.* at 280 n. 6. Indeed, the civil commitment statute "bears striking similarities to the VAWA provision struck down in *Morrison*" because it both "provides a civil remedy aimed at the prevention of noneconomic sexual violence" and because it is "not, in any sense of the phrase, economic activity." *Id.* at 279–80 (quoting *United States v. Morrison*, 529 U.S. 598, 613 (2000)).

Nevertheless, the Supreme Court upheld the law as a proper exercise of Congress' Necessary and Proper power. *Comstock*, 130 S.Ct. at 1965; *see also id* at 1966–67 (Kennedy, J., concurring in the judgment) ("Respondents argue that congressional authority under the Necessary and Proper Clause can be no more than one step removed from an enumerated power. This is incorrect."). This Supreme Court holding—that a law which cannot be

sustained under *Raich* nevertheless may be sustained under the Necessary and Proper Power—defeats the district court's conclusion.

As *Comstock* makes clear, the proper standard for determining whether a law fits within Congress' Necessary and Proper power is not the standard articulated by the district judge. Rather, "in determining whether the Necessary and Proper Clause grants Congress the legislative authority to enact a particular federal statute, [courts] look to see whether the statute constitutes a means that is rationally related to the implementation of a constitutionally enumerated power." *Comstock*, 130 S.Ct. at 1956.

B. The Minimum Coverage Provision is "Reasonably Adapted" To Congress' Legitimate Ends Of Regulating Interstate Commerce in the Health Market and Ensuring that Federal Health Care Spending is Not Wasted

To accomplish its goals of improving health outcomes, extending insurance coverage and promoting financial security against health costs, the ACA creates an interconnected network of subsidies and regulations. Most notably, the Act prohibits insurers from denying coverage to consumers with preexisting conditions or charging them higher premiums, ACA § 2704, and it provides tax subsidies for insurance coverage to individuals with incomes between 133% and 400% of the poverty line. § 1401–02, 2001. Without the minimum coverage provision, these two provisions will be severely

undermined. Rather than ensuring equal access to insurance for Americans with disabilities or preexisting conditions, the ACA's preexisting conditions provision would threaten the nationwide individual insurance market if it does not take effect in conjunction with a minimum coverage provision. Likewise, the generous subsidies offered by the ACA will diminish drastically in value absent a minimum coverage provision.

1. Removing The Minimum Coverage Provision Would Drive Up The Costs of Care For The Uninsured and Shift These Costs To Persons With Insurance

Many health conditions and illnesses, if caught early and treated with appropriate follow-up care, can be relatively inexpensive to resolve. Many conditions can be avoided altogether through preventive care. Yet if these conditions or illnesses do not receive prompt and appropriate treatment, they can often require hospitalization or otherwise deteriorate into a serious condition requiring expensive care. *See* Institute of Medicine, Health Insurance is a Family Matter 106 (2002). Because federal law requires virtually all emergency rooms to stabilize patients regardless of their ability to pay, *see* Emergency Medical Treatment and Labor Act, 42 U.S.C. § 1395dd., the cost of this expensive care winds up being transferred to patients with insurance or to government programs such as Medicare or Medicaid. Accordingly the minimum coverage provision is reasonably

adapted to ensuring that government health care spending is not "frittered away" on preventable health care costs. *Sabri*, 541 U.S. at 605.

The likelihood that a patient will receive adequate preventive care or early treatment is directly related to whether the patient is insured. One study determined that children enrolled in a public health insurance plan were 15 percentage points more likely to receive preventive care than those who were not. Institute of Medicine, America's Uninsured Crisis: Consequences for Health and Health Care 61 (February 2009) ("Uninsured Crisis"). Likewise, multiple studies found that uninsured children are "less likely to be up-to-date on their immunizations than insured children, controlling for observed characteristics of the children." *Id.* Use of dental services also increases between 16 and 40 percentage points among children who are insured. *Id.* at 62.

The data for adult patients is ever starker:

> [C]hronically ill adults who lacked health insurance had five to nine fewer health care visits per year than chronically ill adults who have health insurance. Uninsured adults with chronic illnesses were much more likely than their insured peers to go without any medical visits during the year—even when they were diagnosed with serious conditions such as asthma (23.4 of uninsured adults with no visits vs. 6.2 percent of insured adults), COPD (13.2 vs. 4.0 percent), depression (19.3 vs. 5.2 percent), diabetes (11.0 vs. 5.2 percent), heart disease (8.7 vs. 2.9 percent), or hypertension (12.7 vs. 5.3 percent).

> Similarly, uninsured adults with asthma, cancer, COPD, diabetes, heart disease, or hypertension are at least twice as likely as their insured peers to say that they were unable to receive or had to delay receiving a needed prescription[.]

Id. at 65. Likewise, routine preventive care such as "mammography, Pap testing, cholesterol testing, and influenza vaccination" is far less common among adults who experience frequent periods of uninsurance. *Id.* While women who are consistently insured have a 76.7 percent chance of receiving mammographies, that chance declines to 34.7 percent for women who experience frequent periods of uninsurance. *Id.* Uninsured adults are also much less likely to have a continuing relationship with a single provider. Among uninsured adults, "19 percent with heart disease, 14 percent with hypertension, and 26 percent with arthritis do not have a regular source of care, compared with 8, 4, and 7 percent, respectively, of their insured counterparts." Institute of Medicine, Care Without Coverage: Too Little, Too Late 29 (2002) ("Care Without Coverage"). This disparity is troubling because patients with chronic conditions often must "modify[] their behavior, monitor[] their condition and participat[e] in treatment regimens" in order to keep their condition under control. *Id.* at 57. Such tasks require patients to develop a complex understanding of their condition and to master tasks that do not come naturally to persons without education or training in the health sciences. Thus, a patient's continuing relationship with a single

provider who can answer their questions and monitor their care is "a key to high-quality health care" for persons with chronic conditions. *Id.*

There is robust data demonstrating that uninsured patients' diminished access to care causes their medical conditions to deteriorate. One study found that "near-elderly adults who lost their insurance were subsequently 82 percent more likely than those who kept their private insurance to report a decline in overall health." Uninsurance Among Adults 469. The rate of asthma-related hospital stays for children with asthma in New York dropped from 11.1 percent to 3.4 percent when those children were enrolled in a state insurance program. Peter G. Szilagyi, et al., *Improved Asthma Care After Enrollment in the State Children's Health Insurance Program in New York*, 117 Pediatrics 486, 491 (2006). Uninsured children diagnosed with diabetes are "more likely to present with severe and life-threatening diabetic ketoacidosis" than insured children with the same condition. Uninsured Crisis at 71. Among stroke patients, "[t]he mortality risk of uninsured patients was 24% to 56% higher than that of their privately insured peers for acute hemorrhagic and acute ischemic stroke, respectively." Jay J. Shen and Elmer L. Washington, *Disparities in Outcomes Among Patients With Stroke Associated With Insurance Status*, 38 Stroke 1010, 1013 (2007). Likewise, "5-year survival rates for uninsured adults were significantly lower than for

privately insured adults diagnosed with breast or colorectal cancer—two prevalent cancers for which there are not only effective screening tests, but also treatments demonstrated to improve survival." Uninsured Crisis at 78. Indeed, a recent Institute of Medicine report documented dozens of empirical studies linking uninsurance with poor health outcomes and deteriorated medical conditions. *See generally* Uninsured Crisis.

When uninsured patients fail to receive preventive care, continuing care or early treatment, their healthcare needs and the cost of meeting those needs still require them to participate in the health care market. As a condition of their hospital's participation in Medicare, hospital emergency departments must stabilize any patent who seeks treatment for an emergency medical condition regardless of the patient's ability to pay. *See* Emergency Medical Treatment and Labor Act, 42 U.S.C. § 1395dd. Thus, an uninsured patient whose condition deteriorates because they are unable to afford less expensive preventive or early care will nonetheless receive expensive emergency treatment for that condition. *See* Care Without Coverage at 58 (indicating that many uninsured patients "identify an emergency department as their regular source of care"). The cost of this uncompensated care is then distributed to other patients or to government health programs such as Medicare or Medicaid. According to one study, this cost shifting adds, on

average, $410 to each individual insurance premium and $1,100 to each family premium. Ben Furnas & Peter Harbage, Ctr. for Am. Progress, *The Cost-Shift from the Uninsured* 2 (March 24, 2009) ("Cost-Shift").

Uninsured patients' likelihood to delay care and the subsequent deterioration of health also drive up Medicare costs. A twelve-year study of patients approaching the age of Medicare eligibility found that previously uninsured patients with cardiovascular disease (hypertension, heart disease, or stroke) or diabetes often did not receive widely-available and effective treatments to prevent costly complications if their conditions developed before they qualified for Medicare. As a result, "previously uninsured Medicare beneficiaries with these conditions reported 13 percent more doctor visits, 20 percent more hospitalizations, and 51 percent more total medical expenditures" than similarly situated patients who were insured prior to qualifying for Medicare. Uninsurance Among Adults at 468.

Congress may, through the valid exercise of its spending power, require Medicare hospitals to accept uninsured patients into their emergency rooms as a condition of participation in the Medicare program. The ACA's minimum coverage provision is reasonably adapted to preventing this requirement from driving up the cost of Medicare to taxpayers and increasing the cost of insurance for individual and families receiving

subsidies under the ACA. Accordingly, this provision should be upheld under Congress' Necessary and Proper power. *See Comstock*, 130 S. Ct. at 1957; *Raich*, 545 U.S. at 37 (Scalia, J., concurring in the judgment)); *Sabri*, 541 U.S. at 604–08.

2. Removing the Minimum Coverage Provision Drastically Reduces the Value of the ACA's Subsidies and Imperils the National Insurance Market

Adverse selection occurs when an individual "wait[s] to purchase health insurance until they need[] care," thus enabling them to receive benefits from an insurance plan that they have not previously contributed to. ACA § 10106(a). The consequences of adverse selection is an insurance "death spiral" which can eventually collapse an insurance market. *See* Thomas R. McLean, *International Law, Telemedicine & Health Insurance: China as a Case Study*, 32 Am. J. L. and Med. 7, 21 (2006) ("[A]dverse selection removes good-risk patients from the market, resulting in the need for insurers to raise their premiums; which triggers another round of adverse selection.")

Insurers typically defend against adverse selection by screening potential customers with disabilities or preexisting conditions, but the ACA specifically forbids this practice. § 2704. Thus, the ACA requires most currently healthy Americans to participate in the insurance market to prevent

them from strategically avoiding that market until they become ill or injured. § 10106(a) ("[A minimum coverage provision] is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of preexisting conditions can be sold.")

Because of this adverse selection problem, the Congressional Budget Office estimates that premiums will increase drastically absent a minimum coverage provision:

> CBO and [the Joint Committee on Taxation] estimate that, relative to current law, the elimination of the mandate would reduce insurance coverage among healthier people to a greater degree than it would reduce coverage among less healthy people. As a result, in the absence of a mandate, those who enroll would be less healthy, on average, than those enrolled with a mandate. *This adverse selection would increase premiums for new non-group policies (purchased either in the exchanges or directly from insurers in the non-group market) by an estimated 15 to 20 percent relative to current law.* Without the mandate, Medicaid enrollees would also have higher expected health spending, on average, than those enrolled under current law.

Congressional Budget Office, *Effects of Eliminating the Individual Mandate to Obtain Health Insurance* 2 (June 16, 2010) ("Effects of Eliminating") (emphasis added); *see also* Jonathan Gruber, Ctr. for Am. Progress, *Health Care Reform is a 'Three-Legged Stool* 1 (Aug. 5, 2010) (estimating that the average premium for a non-group health insurance plan would increase 27%

by 2019 if the ACA goes into effect without a minimum coverage provision).

If anything, this CBO estimate greatly underestimates the cost of excising the minimum coverage provision. States which required insurers to cover individuals with preexisting conditions but did not enact a minimum coverage provision experienced far more drastic consequences than the premium spikes CBO predicts. Kentucky, Maine, New Hampshire and Washington each lost most or all of their individual market insurers after those states enacted a preexisting conditions provision without enacting a minimum coverage provision, and the cost of some New Jersey health plans more than tripled after that state enacted a similar law. *See* Vickie Yates Brown, et al., *Health Care Reform in Kentucky - Setting the Stage for the Twenty-First Century?*, 27 N. Ky. L. Rev. 319, 330 (2000) ("Health Care Reform in Kentucky"); Adele M. Kirk, *Riding the Bull: Experience with Individual Market Reform in Washington, Kentucky and Massachusetts*, 25 J. of Health Politics, Pol'y and L. 133, 140, 152 (2000) ("Riding the Bull"); Maine Bureau of Insurance, *White Paper: Maine's Individual Health Insurance Market* 5, 8, (January 22, 2001) ("Maine's Individual Health Insurance Market"), Alan C. Monheit et al., *Community Rating and*

Sustainable Individual Health Insurance Markets in New Jersey, 23 Health Affairs 167, 169–70 (2004).

As the experience of these states and the weight of economic evidence demonstrates, the minimum coverage provision is necessary to prevent the preexisting conditions provision from creating a fatal adverse selection spiral—and this is sufficient reason to uphold the minimum coverage provision under the Necessary and Proper Clause. *See Comstock*, 130 S.Ct. at 1956; *see also id.* at 1968 (Kennedy, J., concurring in the judgment) (explaining that Congress may exercise its necessary and proper power to ensure that another provision of law does "not put in motion a particular force . . . that endangers others"). Congress's Necessary and Proper power is at its apex when, as is the case here, there is a certain and empirically-demonstrated link between a provision of law regulating interstate commerce and another provision chosen to ensure that the commercial regulation functions effectively. *See id.* at 1966 (Kennedy, J, concurring in the judgment) ("When the injury is whether a federal law has sufficient links to an enumerated power to be within the scope of federal authority, the analysis depends not on the number of links in the congressional-power chain but on the strength of the chain."); *Raich*, 545 U.S. at 36 (Scalia, J., concurring in the judgment).

Additionally, removing the minimum coverage provision would, in the words of *Sabri*, "fritter[] away" literally hundreds of billions of "taxpayer dollars." 541 U.S. at 605. The Congressional Budget Office determined that eliminating the minimum coverage provision would increase the federal deficit by $252 billion between 2014 and 2020, with approximately 60 percent of this additional debt stemming from increased health care costs. Effects of Eliminating at 1. Yet while the federal government would spend hundreds of billions more without a minimum coverage provision, the nation would receive far less for its investment, as excising the minimum coverage provision "would increase the number of uninsured by about 16 million people, resulting in an estimated 39 million uninsured in 2019." *Id.* at 2.

Because the minimum coverage provision is both necessary to ensure that the preexisting conditions provision is effective and essential to prevent hundreds of billions of dollars from being "frittered away," it falls comfortably within Congress' Necessary and Proper power.

3. A Decision Upholding the Minimum Coverage Provision Would Not Justify the Hypothetical Federal Laws Suggested By the District Court

The district court argues that, were the Affordable Care Act to be upheld, such a holding would require courts to uphold laws requiring individuals to "consume broccoli at regular intervals" or to "buy a General

Motors automobile." *Florida,* U.S. Dist. LEXIS 8822, at *86. This claim, however, ignores the unique nature of the health insurance market.

As explained above, the health insurance market faces a unique "cost shifting" problem, which causes prices in the health care market to behave in a counterintuitive manner. *See* Cost-Shifting at 2 (explaining that uncompensated care provided to the uninsured adds $410 to each individual insurance premium and $1,100 to each family premium). The laws of supply and demand dictate that a law that increased the number of people purchasing cars would also drive up the cost of those cars. Likewise, a law adding more consumers to the vegetable market would drive up the cost of vegetables. Health insurance, by contrast, becomes more affordable when it is more widely purchased. *Id.*

Similarly, the national market for vegetables is not in danger of collapsing if Congress does not require people to buy broccoli. Nor is there a risk that Americans will cease to be able to obtain automobiles absent a law requiring the purchase of GM cars. The nation's individual health insurance market, by contrast, is susceptible to complete collapse if people can wait until they are ill or injured to buy insurance. *See* Riding the Bull at 140 & 152 (describing the catastrophic consequences of enacting a preexisting conditions law without a minimum coverage provision in Kentucky and

Washington); Maine's Individual Health Insurance Market at 5 & 8 (describing same in Maine and New Hampshire).

More importantly, there is no federal law which depends upon mandatory car ownership, mandatory housing ownership or mandatory food purchases in order to function properly in the same way that the ACA's preexisting conditions provision can only function properly in the presence of a minimum coverage provision. Accordingly, the Necessary and Proper Clause does not provide a constitutional basis for such hypothetical laws in the same way that it supports the minimum coverage provision. *See Raich*, 545 U.S. at 38 (Scalia, J., concurring in the judgment) ("[T]he power to enact laws enabling effective regulation of interstate commerce can only be exercised in conjunction with congressional regulation of an interstate market, and *it extends only to those measures necessary to make the interstate regulation effective*." (emphasis added)).

CONCLUSION

For the foregoing reasons, *amici* respectfully submit that the Court should **REVERSE** the decision of the district court.

Dated: April 8, 2011

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE WITH FEDERAL RULE OF APPELLATE PROCEDURE 32(a)(7)(B)

I hereby certify that this brief complies with the type-face and volume limitations set forth in Federal Rule of Appellate Procedure 32(a)(7)(B). The type face is fourteen-point Times New Roman font, and the number of words is 5535.

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CERTIFICATE OF SERVICE

I hereby certify that on April 7, 2011, I filed the foregoing Brief by causing paper copies to be delivered to the Court. Per the instructions of the Court, I also certify that I will cause a copy of this brief to be uploaded to the Court after I am instructed to do so by the Clerk's office. I also hereby certify that, by agreement with counsel, I caused the brief to be served by electronic mail upon the following counsel:

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